STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

January 30, 2009

GENERAL LETTER NO. 6-AP-83

ISSUED BY: Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 6, ***INCOME MAINTENANCE PROGRAMS APPENDIX***, Contents (pages 2, 3, 5, 8, and 10), revised; pages 50, 51 through 54, 118, 119, 120, 236, 237, 238a, 238b, 287, 290, 290a, 294, 302, 310, 350, 372, 373, 374, and 417, revised; page 238c, new; and the following forms:

470-3967	*ABAWD Letter*, revised
470-4374	*Affidavit Concerning Documentation of Citizenship*, revised
470-4374(S)	*Affidavit Concerning Documentation of Citizenship* (Spanish), revised
470-4373	*Affidavit of Citizenship*, revised
470-4373(S)	*Affidavit of Citizenship* (Spanish), revised
470-4386	*Affidavit of Identity*, revised
470-4386(S)	*Affidavit of Identity* (Spanish), revised
470-0487	*Appeal and Request for Hearing*, revised
470-4469	*Child Care Claim Cover Letter*, revised
470-4469(S)	*Child Care Claim Cover Letter* (Spanish), revised
470-1667	*Debt Setoff Credit*, revised
470-3625	*Employer's Statement of Earnings Cover Letter*, revised
470-3625(S)	*Employer's Statement of Earnings Cover Letter* (Spanish), revised
470-4165	*IowaCare Billing Statement*, unchanged
470-4208	*IowaCare Premium Agreement Cover Letter*, revised
470-4208(S)	*IowaCare Premium Agreement Cover Letter* (Spanish), revised
470-4185	*IowaCare Premium Notice Reminder*, unchanged
470-0272	*Lost Form Request*, revised
470-4530	*Notice of Child Care Assistance Overpayment*, new
RC-0008	*Overpayment Recovery Codes*, revised
470-2960	*Reporting Food Assistance Changes*, revised
470-2960(S)	*Reporting Food Assistance Changes* (Spanish), revised
470-2549	*Statement of Citizenship Status*, revised
470-3797	*Treasury Offset Program (TOP) Pre-Offset Notice*, revised

Summary

This chapter is revised to:

- Update the letterhead on the following forms to reflect the new Director, Eugene I. Gessow:
  - 470-3967, *ABAWD Letter*
  - 470-4374, *Affidavit Concerning Documentation of Citizenship*
  - 470-4374(S), *Affidavit Concerning Documentation of Citizenship* (Spanish)
  - 470-4373, *Affidavit of Citizenship*
  - 470-4373(S), *Affidavit of Citizenship* (Spanish)
  - 470-4386, *Affidavit of Identity*
  - 470-4386(S), *Affidavit of Identity* (Spanish)
  - 470-4469, *Child Care Claim Cover Letter*
  - 470-4469(S), *Child Care Claim Cover Letter* (Spanish)
  - 470-1667, *Debt Setoff Credit*
  - 470-3625, *Employer's Statement of Earnings Cover Letter*
  - 470-3625(S), *Employer's Statement of Earnings Cover Letter* (Spanish)
  - 470-4208, *IowaCare Premium Agreement Cover Letter*
  - 470-4208(S), *IowaCare Premium Agreement Cover Letter* (Spanish)
  - 470-3797, *Treasury Offset Program (TOP) Pre-Offset Notice*
- Revise form 470-0487, *Appeal and Request for Hearing*, to:
  - Include the date the appeal was requested for verbal Food Assistance appeals.
  - Add instructions for denying continuation of benefits.
  - Update the e-mail address for submitting completed forms.
- Remove the following obsolete forms and references to them:
  - *Combined PAER/FAIR*, forms 470-4387, 470-4387(S), 470-4387(M), and 470-4387(MS).
  - *Food Assistance Interim Report*, forms 470-4026, 470-4026(S), 470-4026(M), and 470-4026(MS).
  - *Public Assistance Eligibility Report*, forms 470-0454, 470-0454(S), 470-0455, and 470-3719 (Spanish).
- Update the samples of form 470-4165, *IowaCare Billing Statement*, and form 470-4185, *IowaCare Premium Notice Reminder*, to remove the bank routing information at the bottom of the forms.
- Update the e-mail address on form 470-0272, *Lost Form Request*.
- Add form 470-4530, *Notice of Child Care Assistance Overpayment*, to
- Revise RC-0008, *Overpayment Recovery Codes*, to update coding information for Food Assistance trafficking and misuse claims. DIA completes these claims.
- Revise instructions for form 470-0464, *Overpayment Recovery Information Input*, to update coding information for Food Assistance trafficking and misuse of claims. DIA completes these claims.

- Revise forms 470-2960 and 470-2960(S) to:
  - Change the name to *Reporting Food Assistance Changes*, instead of *Changes: How and When to Tell Us*, to make it clear the form is for Food Assistance only.
  - Clarify Food Assistance reporting requirements. Since all households are now on simplified reporting, language is added that households must report if an ABAWD stops working 80 or more hours in a month.
  - Add language to explain the consequences for failing to report changes.
- Revise form 470-2549, *Statement of Citizenship Status*, to reflect that Medicaid requires proof of citizenship and that INS is now referred to as USCIS.

Effective Date

February 1, 2009.

Material Superseded

Remove the following pages from Employees' Manual, Title 6, Appendix, and destroy them:

Page	Date
Contents (page 2)	June 27, 2008
Contents (page 3)	February 1, 2008
Contents (page 5)	January 9, 2009
Contents (pages 8 and 10)	October 31, 2008
470-3967 (after p. 2)	10/08
470-4374 (after p. 12)	2/07
470-4374(S)	1/07
470-4373	2/07
470-4373(S)	1/07
470-4386 (after p. 12b)	10/07
470-4386(S)	10/07
470-0487 (after p. 16)	4/06
50	February 1, 2008
470-2960	1/08
470-2960(S)	1/08
470-4469 (after p. 50j)	3/08
470-4469(S)	3/08
50o, 50p *	July 6, 2007
470-4387	1/07
470-4387(S)	11/07
470-4387(M)	1/07
470-4387(MS)	11/07
51-53 *	February 1, 2008
54	February 16, 2007
470-1667 (before p. 55)	1/07

470-3625 (before p. 95)	6/08
470-3625(S)	10/08
118 *	October 6, 2006
470-4026	1/07
470-4026(S)	11/07
470-4026(M)	1/07
470-4026(MS)	11/07
119, 120 *	February 1, 2008
121, 122	July 6, 2007
470-4165 (before p. 173)	4/06
470-4208 (before p. 181)	10/07
470-4208(S)	10/07
470-4185 (after p. 182)	7/06
470-0272 (after p. 190)	2/08
236	February 1, 2008
237	October 19, 2007
238a *	February 1, 2008
238b *	May 11, 2004
RC-0008 (after p. 280b)	10/07
287, 290	October 19, 2007
290a	March 25, 2005
294	February 16, 2007
302	June 27, 2000
310	February 1, 2008
470-0454	1/07
470-0454(S)	11/07
470-0455	1/07
470-3719 (Spanish)	1/07
311, 312	February 1, 2008
350	October 3, 2008
372-374	February 1, 2008
470-2549 (after p. 408)	11/08
417	February 1, 2008
470-3797 (before p. 421)	4/03

* As forms are added and removed, existing pages are renumbered to eliminate or consolidate gaps. To accommodate these changes, the following form samples need to be refiled:

- Move form 470-3782 to follow page 52 instead of page 50n.
- Move form 470-0006 to precede page 53 instead of following page 50p.
- Move forms 470-2255 and 470-2255(S) to follow page 118 instead of page 120.
- Move form 470-4053 to follow page 238b instead of preceding page 238a.

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

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Page

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STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR
SERVICE AREA MANAGER

Dear

Right now, you can get Food Assistance for only three months from December 1, 2008, through November 30, 2011.

To get Food Assistance for a longer time, you can do one or more of the following things for at least 80 hours a month:

- Work at a job that pays money
- Work at a job that pays you in other ways, like paying off your rent or other things you need
- Help at a non-profit agency (like a food bank)
- Do court-ordered community service

Or, you can also get Food Assistance longer if any of these things change:

- You turn 50 years old
- You have a physical or mental problem that keeps you from working
- You become pregnant
- You eat with someone under age 18 who lives with you, even if it's not all of the time

Remember that if you stop getting Food Assistance, you can always re-apply at anytime.

Please call my office if you:

- Have questions, or
- Need this letter in another language.

I accept collect calls.

Thank you for your cooperation,

Income Maintenance Worker

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR
SERVICE AREA MANAGER

Dear

Re: U.S. Citizenship of

Please fill out the attached *Affidavit Concerning Documentation of Citizenship* for the person named above. A new federal law requires the Department of Human Services to verify U.S. citizenship and identity of all U.S. citizens who get Medicaid. Please tell us why the person listed above does not have or cannot get proof of being a U.S. citizen.

Please return this form by _____, in the enclosed postage-paid envelope. If you need more time to return the form, please call me before the due date and let me know. If you do not return this form or ask for more time by the due date, Medicaid for the person named above may be canceled or denied. If you have any questions, please call me at the number listed below.

Thank you.

Sincerely,

_____
Income Maintenance Worker

_____
Phone

_____
E-Mail

Enclosure

Worker No. _____

Case No. _____

Iowa Department of Human Services

Affidavit Concerning Documentation of Citizenship

1. Information About the Person Who Doesn't Have Proof of Citizenship

Full name (please print)	State ID

2.

Explain why you or the other person listed above does not have or cannot get documentation of citizenship.
Name of the person completing this form, if different from the person listed above (please print).

3. **I state that the above information is true and correct.**

This affidavit is signed under penalty of perjury.

Signature of person completing form	Date

Two individuals will need to complete and return form 470-4373, *Affidavit of Citizenship*, to complete citizenship requirements.

Estimado(a)

REF: Ciudadanía de los EE.UU. de

Por favor llene la *Declaración juramentada relacionada con la documentación de ciudadanía* para la persona mencionada anteriormente. Una nueva ley federal exige que el Department of Human Services verifique la ciudadanía de EE.UU. y la identidad de todos los ciudadanos de los EE.UU. que obtienen Medicaid. Por favor, díganos por qué la persona mencionada arriba no tiene o no puede conseguir un comprobante de que es ciudadano/a estadounidense.

Por favor devuelva este formulario antes del ____ de _____ de _____, en el sobre con timbre pago que se adjunta. Si necesita más tiempo para devolver el formulario, por favor llámeme antes de la fecha límite e infórmeme. Si no devuelve este formulario o no pide más tiempo antes del plazo, podrá cancelarse o negarse el Medicaid para la persona mencionada anteriormente. Si tiene alguna duda, por favor llámeme al número que aparece abajo.

Gracias.

Cordialmente,

_____
Trabajador de Mantenimiento de Ingreso

_____
Teléfono

_____
E-Mail

Anexos

Trabajador No. _____

Número del caso _____

Iowa Department of Human Services

Affidavit Concerning Documentation of Citizenship
(Declaración jurada concerniente a documentación de ciudadanía)

1. Información sobre la persona que no tiene prueba de ciudadanía

Nombre completo (letra de imprenta)	Identificación del Estado

2.

Explique por qué usted o la otra persona listada anteriormente no tiene o no puede obtener documentación de ciudadanía.
Nombre de la persona que llena este formulario, si es distinta de la persona listada anteriormente (letra de imprenta)

3. **Certifico que la anterior información es verdadera y correcta.**

Esta declaración jurada es firmada bajo la gravedad del perjurio.

Firma de la persona que llena el formulario	Fecha

Dos personas deberán llenar y devolver el formulario 470-4373, *Affidavit of Citizenship (Declaración jurada de ciudadanía)*, para completar los requisitos de ciudadanía.

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR
SERVICE AREA MANAGER

Dear

Re: U.S. Citizenship of

Please give the attached *Affidavits of Citizenship* to two people who know that the person named above is a U.S. citizen. At least one of them cannot be related to the person listed above. The two people who fill out and sign these forms will need to tell us why the person listed above does not have or cannot get proof of U.S. citizenship. These two people must also give us proof of their own U.S. citizenship and identity.

Please return this form by _____, in the enclosed postage-paid envelope. If you need more time to return the form, please call me before the due date and let me know. If you do not return this form or ask for more time by the due date, Medicaid for the person named above may be canceled or denied. If you have any questions, please call me at the number listed below.

Thank you.

Sincerely,

_____
Income Maintenance Worker

_____
Phone

_____
E-Mail

Enclosure

Worker No. _____

State ID _____

Case No. _____

Iowa Department of Human Services

Affidavit of Citizenship

1. Information About the Person Completing This Form

Full name (please print)

2. I have personal knowledge of the circumstance that establishes the United States citizenship of the person listed below:

The person's full name who needs to establish citizenship (please print)
The person's place of birth (list city and state)
The person's date of birth

3.

Other things I know that prove the person's citizenship (if you know of any).
Explain why the person does not have documentation of being a United States citizen (if you know).

4. Are you a relative of the person? ☐ Yes ☐ No

5. **I state that the above information is true and correct.**

This affidavit is signed under penalty of perjury.

Signature of person completing form	Date

This affidavit cannot be used until the person completing this form provides original proof of his or her own identity and United States citizenship.

Estimado(a)

REF: Ciudadanía de los EE.UU. de

Por favor entregue las *Declaraciones juramentadas de Ciudadanía* a dos personas que sepan que la persona mencionada anteriormente es ciudadana de los EE.UU. Por lo menos una de ellas no puede estar emparentada con la persona mencionada anteriormente. Las dos personas que llenen y firmen estos formularios deberán informarnos por qué la persona mencionada anteriormente no tiene o no puede obtener una prueba de su ciudadanía de los EE.UU. Estas dos personas también deberán suministrar prueba de su propia ciudadanía de los EE.UU. y de su identidad.

Por favor devuelva esta formulario antes del __ de _____ de ____, en el sobre con timbre pago que se adjunta. Si necesita más tiempo para devolver el formulario, por favor llámeme antes de la fecha límite e infórmeme. Si no devuelve este formulario o no pide más tiempo antes del plazo, podrá cancelarse o negarse el Medicaid para la persona mencionada anteriormente. Si tiene alguna duda, por favor llámeme al número que aparece abajo.

Gracias.

Cordialmente,

_____
Trabajador de Mantenimiento de Ingreso

_____
Teléfono

_____
E-Mail

Anexos

Trabajador No. _____

Identificación del Estado _____

Número del caso _____

Iowa Department of Human Services

Affidavit of Citizenship
(Declaración jurada de ciudadanía)

1. Información sobre la persona que llena este formulario

Nombre completo (letra de imprenta)

2. Tengo conocimiento personal de la circunstancia que establece la ciudadanía estadounidense de la persona mencionada anteriormente:

Nombre completo de la persona que necesita establecer la ciudadanía (letra de imprenta)
Lugar de nacimiento de la persona (listar ciudad y estado)
Fecha de nacimiento de la persona

3.

Otras cosas que yo sé que prueban la ciudadanía de la persona (si conoce alguna).
Explique por qué la persona no tiene documentación como ciudadano/a estadounidense (si lo sabe).

4. ¿Es usted pariente de la persona? ☐ Sí. ☐ No

5. **Certifico que la anterior información es verdadera y correcta.**

Esta declaración jurada es firmada bajo la gravedad del perjurio.

Firma de la persona que llena el formulario	Fecha

Esta declaración jurada no puede ser jurada hasta que la persona que llena este formulario suministre prueba original de su propia identidad y ciudadanía estadounidense.

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR
SERVICE AREA MANAGER

Dear

Re: Identity of

Please fill out the attached *Affidavit of Identity* for the person named above. A new federal law requires the Department of Human Services to verify U.S. citizenship and identity of all U.S. citizens who get Medicaid.

Please return this form by _____, in the enclosed postage-paid envelope. If you need more time to return the form, please call me before the due date and let me know. If you do not return the form or ask for more time by the due date, Medicaid for this person may be canceled or denied. If you have any questions, please call me at the number listed below.

Thank you.

Sincerely,

_____
Income Maintenance Worker

_____
Phone

_____
E-Mail

Enclosure

Worker No. _____

State ID _____

Case No. _____

Iowa Department of Human Services

Affidavit of Identity

1. Information About the Child Under Age 16 or Disabled Person

Please print.

Name
Place of birth (list city and state)
Date of birth

2. Information About Parent, Guardian, Specified Relative, or RCF Administrator

Name of parent, guardian, specified relative, or RCF administrator

I am the parent, guardian, specified relative (for child), or RCF adminstrator (for a disabled person) of the person identified above. I hereby affirm that the information above is true and correct.

3. Signature

This affidavit is signed under penalty of perjury.

Signature of parent, guardian, specified relative, or RCF Administrator	Date

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR
SERVICE AREA MANAGER

Estimado(a)

REF: Identidad de

Por favor llene la *Declaración juramentada la identidad* para la persona mencionado anteriormente. Una nueva ley federal exige que el Department of Human Services verifique la ciudadanía de EE.UU. y la identidad de todos los ciudadanos de los EE.UU. que obtienen Medicaid.

Por favor devuelva este formulario antes del __ de _____ de ____, en el sobre con timbre pago que se adjunta. Si necesita más tiempo para devolver el formulario, por favor llámeme antes de la fecha límite e infórmeme. Si no devuelve el formulario o no pide más tiempo antes del plazo, podrá cancelarse o negarse el Medicaid para este persona. Si tiene alguna duda, por favor llámeme al número que aparece abajo.

Gracias.

Cordialmente,

_____
Trabajador de Mantenimiento de Ingreso

_____
Teléfono

_____
E-Mail

Anexos

Trabajador No. _____

Identificación del Estado _____

Número del caso _____

Iowa Department of Human Services

Affidavit of Identity
(Declaración juramentada de identidad)

1. Información acerca del menor de 16 años o persona incapacitada

Por favor use letra de imprenta.

Nombre
Lugar de nacimiento (listar ciudad y estado)
Fecha de nacimiento

2. Información sobre el padre o guardián, pariente especificado o administrador RCF

Nombre del padre, guardián, pariente especificado o administrador RCF

Yo soy el padre, pariente especificado (para un menor) o administrador RCF (para una persona incapacitada) de la persona mencionada anteriormente. Certifico que la anterior información es verdadera y correcta.

3. Firma

Esta declaración jurada es firmada bajo la gravedad del perjurio.

Firma del padre, guardián, pariente especificado o administrador RCF	Fecha

Iowa Department of Human Services

Appeal and Request for Hearing

Fill out the top part of this form. You do not need to fill out the worker information part.

Name: Last	First	Mi
Mailing Address		
City	State	Zip Code
Phone Number ( )	County	

Check the programs you want to appeal.

- ☐ Family Investment Program (FIP), Refugee Cash Assistance (RCA) or PROMISE JOBS
- ☐ Child Care Assistance
- ☐ Food Assistance
- ☐ Medicaid or Waiver
- ☐ Attribution
- ☐ Administrative Hearing (only for attribution appeals)
- ☐ State Supplementary Assistance
- ☐ Child Support
- ☐ Adoption or Foster Care
- ☐ Other (explain): _____

I want my benefits to continue, if they can. ☐ Yes ☐ No You may have to pay them back if you lose your appeal.

I want an interpreter for my hearing. ☐ Yes ☐ No We will provide an interpreter for you.

If yes, what language do you read? _____ What language do you speak? _____

I want a pre-hearing conference. ☐ Yes ☐ No

Tell us why you are appealing. Please be brief.

Your Signature _____ Date _____

If you want someone to help you with your appeal, please write the person's name and address below. This person will get information about your appeal. **You are not required to list someone here.**

Name	Phone Number ( )		
Mailing Address	City	State	Zip Code

Worker Information

Worker Name	Phone Number ( )	
Worker Number	County/Office	Case Number/SID Number

Will benefits continue or did you reinstate benefits because of this appeal? ☐ Yes ☐ No

If not, why? ☐ Application/recertification ☐ Appellant chose **not** to have benefits continue

☐ Appeal not filed before the effective date ☐ Other (explain) _____

If the consumer says they need an interpreter, what language do they need? _____

The adverse action appealed is the result of a:

☐ DDS report ☐ IFMC decision

☐ LBP PJ worker _____ Office _____

☐ Q.C. report QC worker _____ Office _____

☐ DIA investigation Investigator _____ Office _____

Attach a copy of the NOD being appealed. If it isn't attached, explain why: _____

Tell us your vacation and training schedule for the next 3 months. _____

Instructions

Use of this form is not mandatory. Any written appeal is a valid appeal.

Verbal appeals are valid only in the Food Assistance program. The worker receiving the Food Assistance appeal should record verbal appeals on this form. Be sure to indicate that this is a verbal appeal. Also, include the date the appeal was requested.

If you get a letter stating the consumer wants to appeal, attach the letter to this form. You need to fill in the consumer's information and your information.

If you do not know what the consumer is appealing, you need to indicate what you think the appeal is about. The DHS Appeals Section will ask the consumer for additional information, if necessary. **Do not hold an appeal if you need to get additional information from the consumer.**

On the front of this form, date-stamp all appeals on the date they are received in your office. If you got the appeal in the mail, keep the postmarked envelope and attach it to this form.

Attach a copy of the Notice of Decision that the consumer appealed to this form. Send this to:

Department of Human Services
Appeals Section, 5th Floor
1305 E Walnut St
Des Moines, IA 50319-0114

Send in an appeal summary to the DHS Appeals Section within 10 calendar days of the date the appeal was filed. Do not delay sending in an appeal while you work on your appeal summary.

Send all new appeals to the DHS Appeals Section within one working day of receipt. Be sure to include the Notice of Decision and the postmarked envelope, if applicable. Use local mail if available.

If the appellant requests that their benefits continue, but the appellant does not meet the criteria listed in Employees' Manual 1-E, then issue a manual notice of decision stating that the appellant's request for continuation of benefits while an appeal is pending is denied. The appellant has the right to appeal this action also.

Be sure to indicate your vacation and training schedule for the next 3 months. This will be used when scheduling a hearing.

For more information about appeals, check out the Appeals Section intranet site at http://dhsintranet/appeals/

Page 50 is reserved for future use.

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR
SERVICE AREA MANAGER

Dear

Our office has received your Child Care Provider Claim form.

In processing your claim, corrections have been made or need to be made so you can receive proper payment. Please see below.

We were able to process your claim for the following children. Payment has been made for _____.

We have processed your claim. However, your claim had some errors on it. To ensure timely payments in the future, please see the highlighted sections on the copy of the claim to bill correctly in the future.

- Provider agreement number
- Child's case number
- Incorrect math
- Co-pay
- Incorrect units
- Unit cost
- Child's name
- Service code
- Other:

We were unable to process your claim, so it is being returned to you. Please complete the items listed below and return the claim so it can be processed.

- Provider must sign the form in ink
- A Child Care Attendance Sheet is required
- Provider and/or client must sign the attendance sheet
- Other:

Your claim exceeded the number of units approved for this child on the Notice of Decision. If the family needs additional units approved, they should discuss this with their caseworker. The number of units approved on the Notice of Decision has been

Enclosure: Claim attached

paid. You will need to submit a new claim for these units once information is received from the family to verify the need for additional units.

We were unable to process your claim for the following reasons. Your claim form is attached. You must fill out a NEW claim form to correct these issues so your claim can be processed.

- Billing period for child care provided
- Provider agreement number
- Unit cost is missing
- Child's case number
- Child's name
- Other:

We were unable to process your claim for the following reasons. Your claim is attached.

- You are not an approved provider. Please bill the Department if/when you are approved.
- The children, _____, you are billing for are not eligible for child care assistance.

Sincerely,

Enclosure: Claim attached

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

Nombre del trabajador:

Teléfono del trabajador:

Estimado(a) :

Nuestra oficina ha recibido su formulario de Reclamación del proveedor de Child Care.

Al procesar su reclamación se hicieron o se requiere hacer correcciones para que pueda recibir el pago adecuado. Por favor vea a continuación.

No pudimos procesar su reclamación para los siguientes niños. El pago se ha hecho por .

Hemos procesado su reclamación. Sin embargo ésta tenía algunos errores. Para asegurar pagos oportunos en el futuro, por favor vea las secciones resaltadas de la copia de la reclamación para facturar bien en el futuro.

- ☐ Número de acuerdo de proveedor
- ☐ Copago
- ☐ Nombre del niño
- ☐ Número de caso del niño
- ☐ Unidades incorrectas
- ☐ Cód de servicio
- ☐ Sumas incorrectas
- ☐ Costo de unidad
- ☐ Otros:

No pudimos procesar su reclamación, así que se le está devolviendo. Por favor llene los elementos marcados a continuación y devuelva la reclamación para ser procesada.

- ☐ Proveedor debe firmar formulario en tinta
- ☐ Se requiere una Hoja de Asistencia para el Cuidado de Niños
- ☐ Proveedor y/o cliente deben firmar la hoja de asistencia
- ☐ Otros:

Su reclamación excede el número de unidades aprobadas para este niño en el Aviso de Decisión. Si la familia necesita unidades adicionales, debe discutir esto con el trabajador de su caso. El número de unidades aprobadas en el Aviso de Decisión ha sido pagado. Usted deberá enviar una nueva petición por estas unidades una vez se reciba la información de la familia para verificar la necesidad de unidades adicionales.

Enclosure: Claim attached

No pudimos procesar su reclamación por las siguientes razones. Su formulario de reclamación se encuentra anexo. Debe llenar un **Nuevo** formulario de reclamación para corregir estos problemas para que se pueda procesar su reclamación.

- ☐ Periodo de facturación para la atención suministrada
- ☐ Número de acuerdo de proveedor
- ☐ Falta costo de unidad
- ☐ Número de caso del niño
- ☐ Nombre del niño
- ☐ Otros:

No pudimos procesar su reclamación por las siguientes razones. Su formulario de reclamación se encuentra anexo.

- ☐ Usted no es un proveedor aprobado. Por favor facture al Departamento si/cuando está/é aprobado.
- ☐ Los menores, , para los que usted está facturando no son elegibles para child care assistance.

Otros:

Page 51 is reserved for future use.

Child Support Information Request, Form 470-3782

Purpose	Form 470-3782, *Child Support Information Request*, is a cover letter used in conjunction with the Change Reporting System to collect information for the Family Investment Program and the Medicaid program. This form forwards forms 470-3773, *Absent Parent Information*, and 470-0169, *Requirement of Support Enforcement*.
Source	The Change Reporting System generates form 470-3782 in response to specific answers entered in the Parent Leaves Home (PLH) incident screen narrative.
Completion	When a household report that a parent is leaving or has left the home is entered in the Change Reporting System, the system generates form 470-3782 to forward forms 470-3773, *Absent Parent Information*, and 470-0169, *Requirement of Support Enforcement*, to the household.
Distribution	The system prints two copies. Give one copy to the client and file one copy in the case record.
Data	The Change Reporting System populates the address and worker information and calculates a due date for the return of the requested information.

Claimant's Supplemental Statement, Form 470-0006

Purpose	Form 470-0006, *Claimant's Supplemental Statement*, is used to supply the Department of Inspections and Appeals (DIA), Investigations Division, with information to determine the appropriateness of request to replace a warrant stolen from a client's mailbox.
Supply	Print or photocopy supplies of form 470-0006 from the sample in the manual.
Completion	The payee completes this form at the same time as form 470-0004, *Affidavit as to Forged Endorsement*. The affidavit must be made and signed before an officer authorized to administer oaths generally, and the officer must certify that the officer administered the oath. If there is more than one payee, each person must complete a form.
Distribution	Keep the original *Supplemental Statement* in the client's case file. Forward one copy to DIA Investigations Division, 3rd Fl, 321 E 12th St., Des Moines, Iowa 50319-0083. **Exception:** If a viable, readable copy cannot be obtained, send the original to DIA. If DIA cannot read or discern the payee's signature well enough to make an informed decision as to whether or not to replace the warrant, there will be a delay while the original is requested.
Data	This form must be completed in front of a DHS employee, using the **exact wording and abbreviations as on the endorsement**. This includes the warrant address, not the client's current address (if different). If a question is not applicable, the payee completes the line with "N/A."

Daily Tip Record, Form 470-3777

Purpose	Form 470-3777, *Daily Tip Record*, is used in conjunction with the Change Reporting System to collect information for the Family Investment Program, Food Assistance program, and Medicaid program when it is reported that someone in the household receives tip income.
Source	The Change Reporting System generates form 470-3777 in response to specific answers entered in a Beginning Employment (BEMP) incident screen narrative.
Completion	When it is reported that someone in the household has income from tips, the Change Reporting System generates this form for the household to use to record the tip income.
Distribution	The system prints two copies. File one copy in the case record and give one copy to the client, to be returned with the completed *Review/Recertification Eligibility Document* (RRED).
Data	The Change Reporting System populates the case and worker information areas. The client completes the employer information and the dates and amounts of tips received.

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

This is your receipt for the amount of $_____

This amount of money has been subtracted from what you owe the state. As an earlier letter told you, the money was withheld from your:

- Income tax refund,
- Federal retirement,
- Federal pay,
- Other federal benefits, or
- A state warrant.

This amount may not be subtracted from your balance on your next Account Statement. This will be shown on a future statement.

If you have questions, please call:

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR
[name], SERVICE AREA MANAGER

Dear

To find out if you can [continue to] get benefits, please [sign, date, and have your employer complete and send back the enclosed Employer Statement of Earnings] [have ____ sign, date, and have his/her employer complete and send back the enclosed Employer Statement of Earnings] [sign and date the Employee Permission section of the enclosed Employer Statement of Earnings] [have ____ sign and date the Employee Permission section of the enclosed Employer Statement of Earnings]. [It is your responsibility to get this information to us.] [Please return it to us so we can send it to [your, the] employer.] [Please fill in your employer's name after the word 'Dear.']

[You may be able to get help paying for child care. If you wish to apply for the Child Care Assistance program, please contact our office.]

Please provide this information by [due date]. If you don't, then your benefits may [be denied, be canceled, remain canceled, be canceled or denied].

QUESTIONS?? If you have any questions or need more time to get the information, please call me on or before [due date].

Thank you,

[worker name]
[worker phone number]
FAX: [fax number]
[worker e-mail]

[worker address]

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR
[name], SERVICE AREA MANAGER

Estimado/a

Para averiguar si usted puede [obtener, continuar recibiendo] beneficios, por favor [firme, escriba la fecha y pídale a su empleador que complete y nos envíe el formulario Employer Statement of Earnings (Declaración de Ingresos del Empleador) que se adjunta] [solicítele a _____ que firme, escriba la fecha y le pida a su empleador que complete y nos envíe el formulario Employer Statement of Earnings (Declaración de Ingresos del Empleador) que se adjunta] [firme y escriba la fecha en la sección Autorización del Empleado del formulario Employer Statement of Earnings (Declaración de Ingresos del Empleador) que se adjunta] [solicítele a _____ que firme y escriba la fecha en la sección Autorización del Empleado del formulario Employer Statement of Earnings (Declaración de Ingresos del Empleador) que se adjunta]. [Usted será responsable de hacernos llegar esta información.] [Por favor envíela para que podamos remitírsela [a su, al] empleador.] [Por favor, escriba el nombre de su empleador a continuación de la palabra “Estimado/a”.]

[Usted podría obtener ayuda para pagar la guardería. Si desea solicitar el programa Child Care Assistance (Asistencia para Cuidado Infantil), por favor, comuníquese con nuestra oficina.]

Le agradeceré que envíe esta información antes del [due date]. Si no lo hace, entonces los beneficios podrían [ser denegados, ser cancelados, permanecer cancelados, ser cancelados o denegados].

¿¿PREGUNTAS?? Si desea hacer preguntas o necesita más tiempo para conseguir la información, por favor llámeme el o antes del [due date].

Muchas gracias,

[worker name]
[worker phone number]
FAX: [fax number]
[worker e-mail]

[worker address]

Food Assistance Work Rules, Form 470-2255 and 470-2255(S)

Purpose	Form 470-2255, *Food Assistance Work Rules*, is used to notify each mandatory work registrant what the registrant's rights and responsibilities are and the consequences of failure to comply with the requirements.
Source	The English version of form 470-2255 is printed in pads of 50 two-part carbonized sets. Order supplies from Iowa Prison Industries at Anamosa. The Spanish version can be printed from the on-line manual or photocopied from the paper manual.
Completion	The IM worker issues this form to every mandatory work registrant when: ♦ An application is approved, ♦ A case is approved for recertification, ♦ A client loses exempt status for work registration due to a change in circumstances, or ♦ A new household member who is a mandatory work registrant is added.
Distribution	Give or mail the one copy of the form to the client. At the application or recertification interview, give the household representative the a copy this form for each mandatory registrant in the household. File the other copy of the form in the registrant's case file.
Data	Enter the mandatory work registrant's name and the date the form was given or mailed to the registrant.

Page 119 is reserved for future use.

Pages 120 through 122 are reserved for future use.

S2001

N11V

Iowa Department of Human Services

IowaCare Billing Statement

Date

KEEP THIS INFORMATION FOR YOUR RECORDS

Dear

You must pay a premium to continue to get coverage under the IowaCare program. This is a bill that tells you how much your premium is and when it is due.

Make your check or money order payable to the IowaCare program. Please do not send cash. Send your payment in the enclosed envelope to: Iowa Medicaid Enterprise, PO Box 10391 Des Moines, IA 50306-0391

If you don't pay your premium by the due date, you may no longer be covered by IowaCare.

Payments made on your account are listed below. If payments were listed on another statement, those payments will not show up here.

Month	Premium Amount Due	Due Date	Payment Received	Payment Applied	Date Applied	Refund Amount

Total Owed:

Total Credit:

You may pay in advance. Your payments will be used to pay old unpaid premiums before being used for current or future premiums.

If you have any questions, please call your local county DHS office. Report changes directly to your DHS county worker.

MAIL THIS STATEMENT IN THE ENCLOSED ENVELOPE ← DETACH AT PERFORATION →

$ [redacted]

DETACH AT PERFORATION

Due Date: Amount Due:

If you are unable to pay, you must sign in the box below. This signed statement must be received at the above address. If not received by the above due date you will still owe the premium for this month. Because I have spent or will spend my monthly income on food, housing, utilities, transportation or other health care, I am not able to pay my IowaCare premium for this month. So, I am not able to send the amount on this billing statement.

Signature

Date

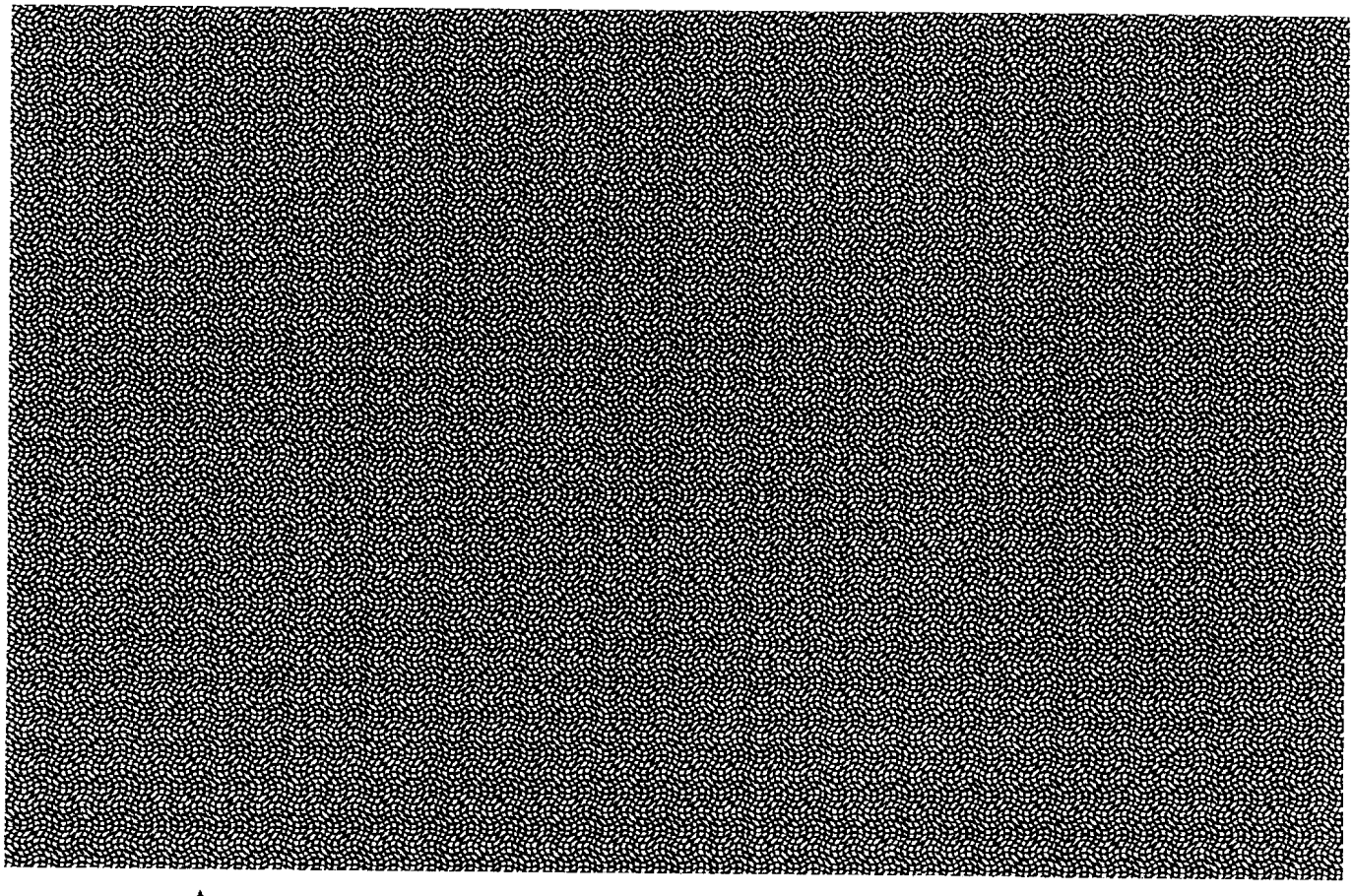
IowaCare
Iowa Department of Human Services
Supply Unit A -- Level Rm. 33
1305 E Walnut St
Des Moines, IA 50319-0114

Return Service Requested

470-4165 (4/06) H4165B

PRESORTED
FIRST-CLASS MAIL
US POSTAGE
PAID
DES MOINES, IA
PERMIT NO. 1195

REMOVE THESE SIDE EDGES FIRST
FOLD, CREASE AND TEAR ALONG PERFORATION



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FOLD, CREASE AND TEAR ALONG PERFORATION

REMOVE SIDE EDGES FIRST
THEN FOLD, CREASE AND TEAR THIS STUB ALONG PERFORATION

Iowa
Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR
SERVICE AREA MANAGER

Dear

You applied for or were recently canceled from Medicaid. Application for Medicaid is also considered an application for IowaCare. It has been determined that you may qualify for IowaCare. However, before the Department can determine if you are eligible for IowaCare, you must sign the enclosed form and return it to the Department of Human Services by _____. You must also provide verification of citizenship and identity for _____. Please see the attachment for a list of acceptable documents.

If you have questions, please call me.

Sincerely,

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR
SERVICE AREA MANAGER

Estimado(a)

Usted solicitó o recientemente se le canceló de Medicaid. La solicitud para Medicaid también se considera una solicitud para IowaCare. Se ha determinado que usted puede calificar para IowaCare. Sin embargo, antes que el Departamento pueda determinar si usted es elegible para IowaCare, usted debe firmar el formulario anexo y devolverlo al Department of Human Services antes del __ de _____ de ____. También debe proporcionar verificación de la ciudadanía e identidad de _____. Por favor, vea el anexo con la lista de los documentos apropiados.

Si desea hacer preguntas, por favor llámeme.

Cordialmente,

FAX:

S2001

Iowa Department of Human Services

IowaCare Premium Notice Reminder

KEEP THIS INFORMATION
FOR YOUR RECORDS

Dear :

You were approved for IowaCare. When you applied for IowaCare, you agreed to pay a monthly premium.

We did not get a payment for .

If you already sent in your payment, please ignore this notice. If you have not sent in your payment, please do so right away so your IowaCare coverage does not end.

IMPORTANT: If your income has gone down, you may be able to get a lower premium. Please call your county office if you have questions.

If you do not have your billing statement, please tear off the bottom of this letter and mail it back with your payment in the envelope provided. You do not need a stamp.

If you no longer have the envelope, mail your payment to: Iowa Medicaid Enterprise
P.O. Box 10391
Des Moines, IA 50306-9013

If you have any questions, please call your local county DHS office. Report changes directly to your DHS county worker.

Thank you.
The IowaCare Program

MAIL THIS STATEMENT IN THE ENCLOSED ENVELOPE ▲— DETACH AT PERFORATION —▲

Due Date: Amount Due: [redacted]

If you are unable to pay, you must sign in the box below. This signed statement must be received at the above address. If not received by the above due date you will still owe the premium(s) due in this month. Because I have spent or will spend my monthly income on food, housing, utilities, transportation or other health care, I am not able to pay my IowaCare premium for this month. So, I am not able to send the amount that I owe for this month's premium.

Signature _____ Date _____

DETACH AT PERFORATION

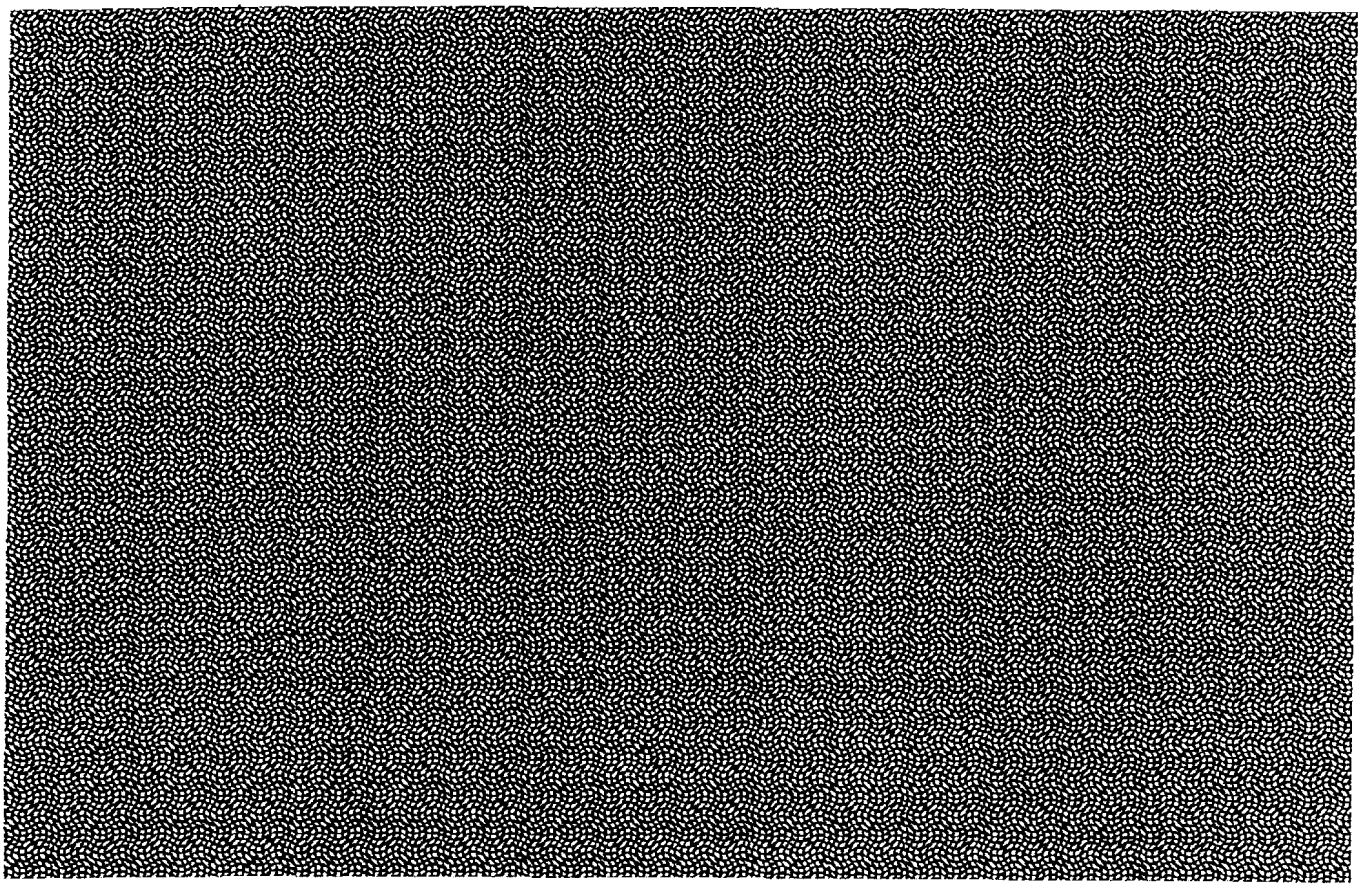
IowaCare
Iowa Department of Human Services
Supply Unit A -- Level Rm. 33
1305 E Walnut St
Des Moines, IA 50319-0114

Return Service Requested

470-4185 (7/06) H4185B

PRESORTED
FIRST-CLASS MAIL
US POSTAGE
PAID
DES MOINES, IA
PERMIT NO. 1195

REMOVE THESE SIDE EDGES FIRST
FOLD, CREASE AND TEAR ALONG PERFORATION



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REMOVE SIDE EDGES FIRST
THEN FOLD, CREASE AND TEAR THIS STUB ALONG PERFORATION

Iowa Department of Human Services

LOST FORM REQUEST

INSTRUCTIONS: For each request for replacement, complete the corresponding numbers, the document type, the worker number, date, and county, and the signature. Use an X to indicate each document you need. For Medically Needy subsystem: Double-click the Send button at the bottom of the form and e-mail to IMEMedicallyNeedy@dhs.state.ia.us.

MMIS Medically Needy Subsystem

Case Number

Complete and send to IME's Medically Needy Unit

From	To
MM DD YY	MM DD YY

- ☐ ESTD
- ☐ BSTD
- ☐ NOSS

Automated Benefit Calculation System

Case Number

- ☐ Tickler
- ☐ Fam. Comp.

Income and Eligibility Verification System

State I.D.

Case Name (Last Name)	First Name

SSN

ABC Case Number

- ☐ Unemployment
- ☐ Employment Service Wages
- ☐ Bendex
- ☐ SSA Earnings
- ☐ Validation Error Report
- ☐ IRS

* *

Worker No.	Date	County	Completed by:

Notice of Cancellation, Forms 470-0500, 470-0500(S), 470-1968, and 470-1968(S)

Purpose	The *Notice of Cancellation* is used to notify FIP, RCA, RMA, and FMAP-related Medicaid participants of cancellation because of failure to complete the *Review/Recertification Eligibility Document* (RRED), form 470-2881, 470-2881(S), 470-2881(M), or 470-4083(MS).
Source	Form 470-0500 and 470-0500(S) are system-generated. Workers can complete the English or Spanish manual version, form 470-1968 or form 470-1968(S), on line using the template on the DHS Intranet eForms web page.
Completion	This form is used only once in a calendar month. The data processing system issues the form when the system shows that the RRED was not received on cases that are active, suspended, or pending. The worker may issue the form manually when: ♦ The client fails to return an out-of-cycle form; or ♦ An incomplete RRED is received.
Distribution	Send the original to the client. Include a postage-paid envelope. File the copy in the case record. If there is a guardian or conservator, send that person a photocopy of the notice. Return an incomplete RRED to the client along with the *Notice of Cancellation* with the incomplete areas indicated in red. (Photocopy the report form before returning it.)
Data	To prepare the form manually, enter the following information: ♦ The local office address. ♦ The worker number and the county number. ♦ The worker's name. ♦ The nine-digit case number and check digit. ♦ The case name and current mailing address.

- A check for each type of aid affected.
- The effective date of cancellation (MM/DD/YY). This is the first day of the payment month that corresponds to the budget month for which the form was to be completed.
- A check beside each applicable reason.
- The proof the client is required to send.

Iowa Department of Human Services

Notice of Child Care Assistance Overpayment

Date: Account Number:

Keep this part

If you have questions about repayment, call **1-800-572-3945** (toll free). If you have questions about the establishment of this claim, call your worker or local DHS office.

Our records show that you owe money to the Department of Human Services (DHS). The reason is checked below. The amount that you owe is $ for the months of :

1 ☐ A mistake by you that gave you child care assistance in error.

2 ☐ A mistake by DHS that gave you child care assistance in error.

3 ☐ A mistake by a provider that caused DHS to pay the provider incorrectly for child care services.

4 ☐ A mistake by DHS that incorrectly paid a provider for child care services.

This overpayment happened because of

Step 1: Decide What You Need to Do

- If you ***agree*** that an overpayment has been made:
  1. Fill out the repayment agreement below.
  2. Make sure you sign and date the agreement.
  3. Using the enclosed envelope, return the agreement within 20 days.
- If you ***do not agree*** that you owe DHS money or if you do not agree with the amount, you may appeal within **30 calendar days** of the date on the first notice that is sent to you. Your appeal rights are explained on the back of this letter.

Step 2: Choose a Payment Plan

Plan 1: Pay the full amount in one payment.

Plan 2: Make monthly payments.

Plan 3: Pay part of what you owe now and pay the rest in monthly payments.

Monthly Payments: If you choose Payment Plan 2 or 3, your monthly payments cannot be less than $50 or the amount you owe divided by 60 (one payment monthly for five years), whichever is greater. You can pay the entire balance at any time.

Note: If your household's income changes, you may ask to change this agreement.

Step 3: Fill Out and Mail the Agreement to Pay – Remember to:

- Fill in all the blanks.
- Choose a payment plan.
- Sign and date the form.

Mail the form to:
Iowa Department of Inspections and Appeals
Overpayment Recovery Unit
321 E 12th St, 3rd Floor
Des Moines, Iowa 50319-0083

After we get your signed agreement, you will get a bill with instructions on how to make payments.

Actions to Collect the Debt

The debt has been referred to the Department of Inspections and Appeals (DIA) for collection. DIA will collect on this debt by doing one of the following:

- Bill you for the debt, or
- If you are not making payments and you are past due on your account:
  - Take your Iowa income tax refund, or
  - Take money that is owed to you by any state agency. For example, all or part of your income tax refund or state wages.
- If you gave wrong information on purpose or kept information from DHS to get more benefits than you were eligible for, your case can be referred for a criminal investigation.
- File a civil suit to collect the debt.

You Have the Right to Appeal

If you do not agree that a child care debt has been made, you may appeal. **There is no fee or charge for an appeal.** (441 Iowa Administrative Code Chapter 7)

What is an appeal? An appeal is asking the Department to look one more time at the decision you think is wrong.

How to appeal? To appeal, follow these steps:

- Complete the appeal form on-line at https://dhssecure.dhs.state.ia.us/forms/ or
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

How long do I have to appeal?

Be sure to mail your letter or submit your appeal electronically within 30 days of the date on the first overpayment notice. The Director of the Department of Human Services (DHS) can approve a late appeal if there is a good reason for the appeal being late. **No hearing will be held for an appeal sent more than 90 days after the date on your first notice.**

What happens when DHS receives your appeal?

DHS will review your appeal and decide if a hearing will be held. A hearing is a meeting with you, a DHS representative and an Administrative Law Judge.

- If DHS decides to have a hearing, you will get a letter telling you what you need to do for the hearing. At the hearing, you can talk about your case. You may have a friend or relative or other person explain your case.

  For information about legal services, you may call Iowa Legal Aid at 1-800-532-1275, or call 243-1193 if you live in Polk County. You may have to pay for these legal services. If you do, your payments will be based on your income. You may also choose to have an attorney at the hearing, but DHS will not pay for the attorney.

- If DHS decides not to have a hearing, you will get a letter telling you the reason, and what steps you can take.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.

Iowa Department of Human Services

Notice of Child Care Assistance Overpayment

Agreement to Pay

Mail this part

Name: Account Number:

I, _____, agree to pay the Department of Human Services by:
(First Name, Middle Initial, and Last Name)

☐ ***Plan 1*:** Pay the full amount in one payment

☐ ***Plan 2*:** Make monthly payments of $_____ per month
Starting (date) _____

☐ ***Plan 3*:** Pay $_____ now and pay the rest in monthly payments of $_____ per month

By signing this agreement, I understand that

- If I choose Payment Plan 2 or 3, my monthly payments cannot be less than $50 or the amount I owe divided by 60 (one payment monthly for five years), whichever is greater.
- I can pay the balance off at any time.
- If I sign this agreement and do not follow its terms, it will break the contract and action may be taken against me.

Signature	Phone	Date

For Office Use Only:

Signed: Date: Title:

Notice of Child Care Assistance Overpayment, Form 470-4530

Purpose	Form 470-4530 informs the debtor on a Child Care Assistance claim of the amount and reason for the overpayment and requests repayment.
Source	Form 470-4530 is generated monthly by the Overpayment Recovery System.
Completion	The form is printed for debtors who: ♦ Have a Child Care Assistance claim entered on the Overpayment Recovery System, and ♦ Have not submitted an agreement to repay the debt. This form is partly completed by the Overpayment Recovery System. The debtor is responsible for completing the agreement to repay. At least one form must be sent before a debt setoff takes place. State income tax refunds, rebates, or other state payments, including state employee wages may be offset to pay the debt.
Distribution	One copy is mailed from Central Office.
Data	The system completes: ♦ The amount of overpayment, and ♦ The type of error, and ♦ The reason for the overpayment. The debtor completes the repayment terms.

Notice of Child Care Assistance Provider Sanction, Form 470-4053

Purpose	The *Notice of Child Care Assistance Provider Sanction* is used to notify families that their child care provider has been sanctioned by the Child Care Assistance (CCA) program and that they may need to select another provider if they want CCA to continue paying for their child care services.
Source	This form is not available in printed form. CCA workers shall complete this form on line using the template on the DHS Intranet eForms web page. PROMISE JOBS workers shall complete this form on line using the template provided by DHS.
Completion	When a sanction is imposed, the DHS child care worker or PROMISE JOBS worker shall complete a *Notice of Child Care Assistance Provider Sanction* for every CCA family using the sanctioned provider.
Distribution	Mail one copy to the family and keep a copy in the family's DHS or PROMISE JOBS case file. Provide a copy of this letter to PROMISE JOBS if necessary.
Data	The template automatically enters the notice date. Use the "tab" key to navigate between fields requiring data entry. Enter the following information: ♦ The family's name and mailing address ♦ The parent or guardian's first name ♦ The child care provider's name Click or tab to the text box and: ♦ Choose "Yes" if the letter is going to a CCA family or "No" if the letter is going to a family who does not get CCA. ♦ Select the applicable sanction type. ♦ Click the "insert language" button. ♦ Enter the sanction effective date.

If the letter is going to a CCA family, enter:

- The child care worker's name
- The county name
- The worker's phone number

If the letter is **not** going to a CCA family, enter:

- The county name
- The DHS office phone number

Once all fields have been entered, print a copy of the letter for the family and another copy for the CCA case file, if any.

OVERPAYMENT RECOVERY CODES

3 Prefix

- I State ID number
- S Social security number or federal ID number
- P Provider number
- H *hawk-i*

11 Language Indicator

- E English
- S Spanish

13 Case Status

- A Active on ABC for any program
- C Case is closed on ABC
- P Pending or for PJ or TCC provider overpayments

17 Program

FIP	01	FIP
Food Assistance	10	Food Assistance trafficking or misuse (DIA entry only)
	11	IPV (Appeal decision final)
	12	Inadvertent household error or agency error
Medicaid	20	HIPP
	21	FMAP-related client
	22	Other program client
	27	Third-party liability
	28	Medical transportation
State Supp	25	State Supplementary Assistance
Refugee	31	Refugee Cash Assistance
	32	Refugee Medical Assistance
CCA	15	Client overpayment
	16	Registered provider overpayment
	17	Non-registered provider overpayment
	18	Licensed provider overpayment
	19	Exempt facility provider overpayment
PROMISE JOBS	65	Transportation
	67	Other PROMISE JOBS expense allowances (except child care)
State Warrant	69	Medicaid divestiture
	92	Stolen warrant - FIP grant
	93	Stolen warrant - non-FIP
hawk-i	70	*hawk-i*
IowaCare	71	IowaCare

22 Cause

- 01 Unreported earned income
- 02 Unreported unearned income
- 05 Unreported child support
- 06 Absent parent in home
- 07 Assistance for child not in the home or not in school
- 08 Unreported resources
- 09 Check forgery
- 10 Unreported marriage
- 11 Receiving assistance in more than one county or state
- 12 Unable to locate client
- 14 Pending appeal
- 15 Agency/administrative error
- 16 Failure to provide correct information
- 17 Failure to timely report changes
- 19 Duplicate warrants
- 21 Assistance received greater than amount on NOD
- 23 Loss of residence
- 24 Rate change
- 25 Failure to participate in program
- 27 Other
- 28 Buy-in
- 29 Child care provider not registered or licensed
- 31 Misrepresented household size
- 39 Client disaster error
- 40 Agency disaster error
- 63 Transfer of assets
- 64 Not uninsured
- 65 Age misrepresented
- 66 Food Assistance trafficking
- 67 Misuse of Food Assistance benefits
- 68 Unpaid IowaCare premiums
- 69 IowaCare premiums paid in error

23 Referral Source

- 01 IEVS match
- 02 Caseworker
- 03 Quality control
- 04 DIA investigator
- 05 Child Support Recovery Unit
- 06 Anonymous tips
- 09 Federal audits
- 10 State audits
- 11 Other state agencies
- 13 Division of Criminal Investigation
- 15 Reports by client
- 16 Law enforcement official
- 17 POS rate change
- 18 Other
- 19 Third Party Administrator

24 Appeal Status

- 1 No appeal pending
- 2 Appeal pending
- 3 Appeal decided; overpayment exists
- 4 Appeal decided; no overpayment exists
- F Action discontinued or closed; stolen warrant
- K Replaced warrant
- R Referrals to revenue for collection

25 Fraud Status

- 1 Stolen warrant
- 2 Pending an appeal
- 3 Fraud or intentional program violation
- 4 Non-fraud but question of fraud exists; inadvertent household error
- 5 Non-fraud (no question of fraud), agency error

27 Reason (Food Assistance only)

- 1 Household failed to provide correct or complete information
- 2 Household failed to report or timely report changes
- 3 Household found to be ineligible or eligible for fewer benefits pending a hearing decision
- 4 Agency error in computing household's level of benefits
- 5 Agency error in issuing Food Assistance allotment
- 7 Trafficking or misuse of benefits

28 Send Letters

- Y Yes
- N No

17. Program: Enter the program area in which the overpayment occurred. Use the following codes:

01 FIP, other than FIP Refugee

10 Food Assistance trafficking or misuse (DIA entry only)

11 Food Assistance intentional program violation (appeal decision final)

12 Food Assistance household error or agency error

15 Child Care Assistance client overpayments (for overpayments that occurred after 4/30/01)

16 Child Care Assistance registered provider overpayments that occurred after 4/30/01

17 Child Care Assistance non-registered provider overpayments that occurred after 4/30/01

18 Child Care Assistance licensed provider overpayments that occurred after 4/30/01

19 Child Care Assistance exempt facility provider overpayments that occurred after 4/30/01

20 Health Insurance Premium Payment program

21 FMAP-related Medicaid

22 Other Medicaid (SSI-related, Medically Needy, MAC)

25 State Supplementary Assistance

27 Medicaid third-party liability

28 Medical transportation

31 Refugee Cash Assistance

32 Refugee Medical Assistance

65 PROMISE JOBS transportation

67 Other PROMISE JOBS expense allowances

69 Medicaid divestiture

70 ***hawk-i*** (Use only with prefix H.)

71 IowaCare

92 Stolen warrant (FIP monthly grant)

93 Stolen warrant (non-FIP funds)

28 Buy-in
29 Child care provider not registered or licensed
31 Misrepresented household size
39 Client disaster error
40 Agency disaster error
63 Transfer of assets
64 Not uninsured (Use only with prefix H, ***hawk-i***.)
65 Age misrepresented (Use only with prefix H, ***hawk-i***.)
66 Food Assistance trafficking
67 Misuse of Food Assistance benefits

23. Referral source: Enter the code for the source that originally brought a possible overpayment to the attention of the Department. Use the following codes:

01 IEVS match
02 Caseworker
03 Quality control
04 DIA investigator
05 Child Support Recovery Unit
06 Anonymous tips
09 Federal audits
10 State audits
11 Other state agency
13 Division of Criminal Investigation
15 Reports by client
16 Law enforcement official
17 POS rate change
18 Other
19 Third-party administrator (Use only with prefix H, ***hawk-i***.)

24. Appeal status: Enter the code indicating whether the client has requested an appeal (not an administrative disqualification hearing) and the disposition of the appeal.

1 No appeal pending
2 Appeal pending
3 Appeal decided; overpayment exists
4 Appeal decided; no overpayment exists

When entering an update because the debtor files an appeal or a final decision is issued, complete fields 17 through 21 to identify the pertinent claim. (DIA uses this field to denote the status of claims that have been referred for further collection efforts. The appeal codes take precedence over those entered by DIA.)

25. Fraud status: Enter the code indicating whether the case has the potential of being referred for fraud or has already been determined to be fraud.

1 Stolen warrant.

2 Pending an appeal. Use with cause code 14 (pending appeal).

3 Fraud or intentional program violation. Use only after fraud has been determined by a court ruling or intentional program violation has been determined by an administrative disqualification hearing.

4 Not fraud, but question of fraud exists; or inadvertent household error.

5 No question of fraud (agency error). Use only with cause codes 15 and 40 (administrative or agency errors).

26. *hawk-i* case #: Enter only if this is a ***hawk-i*** claim. Otherwise, leave blank.

27. Reason(s): For Food Assistance only, enter up to four codes for the reasons for the overissuance. (FIP, Medicaid, ***hawk-i***, Child Care Assistance, and State Supplementary Assistance demand reasons are printed from Item 22, cause code.) Codes are:

1 Your household failed to provide the county office with correct or complete information.

2 Your household failed to report/timely report changes in its circumstances as required.

3 Your household was found to be ineligible or eligible for fewer benefits than it received pending a fair hearing decision.

4 Agency error in computing your household's level for benefits.

5 Agency error in issuing your Food Assistance allotment.

7 Trafficking or misuse of benefits.

If the person is an employee of a state agency, name the county of location where the person is employed. List the office telephone number and the type of caseload carried.

List all related documents, giving the date of each document (examples: application, RRED, NOD). In addition, list all signed statements available from either the recipient or a collateral source.

Maintain all related documents in the case record until complete recovery has been made or the Division of Investigations requests the documents.

Worker: Sign the form when it is completed.

Date: Enter the date the form is completed.

- Enter the client participation amount for the first month for a child entering the facility and for the last month for a child leaving the facility.

  Send a copy of this form to the service worker and to the Foster Care Accounting Unit. Foster Care Accounting uses these dollar amounts in crediting the proper fund when the child's income is received by Foster Care Accounting.

- Also enter the gross amount of unearned income and earned income of the child to assist the Foster Care Accounting Unit in understanding client participation and sending the proper amount of personal needs allowance when the child's income is received in foster care accounting.

IFMC decision: Complete this section when a child in foster care or subsidized adoption enters a PMIC. Check whether IFMC has approved or denied the level of care and send to the service worker. Attach a copy of form 470-0042, *Case Activity Report*.

Other:

- Review form attached. Check this box when a Medicaid review is required. Attach a copy of the review form when requesting help of the service worker for completion of the form:
  - Form 470-2881, 470-2881(S), 470-2881(M), or 470-4083(MS), *Review/Recertification Eligibility Document* (RRED), for FMAP-related eligibles, or
  - Form 470-0442, Application for Medical Assistance or State Supplementary Assistance, for SSI-related eligibles.
- Visit days exceed maximum. Check this box and send copy of form 470-0042, *Case Activity Report*, when visit days will exceed maximum.
- Runaway or discharge. Check this box and send copy of form 470-0042, *Case Activity Report*, when the facility reports that the child has run away, or there is an unplanned or planned discharge.
- Signature and date. The worker sending the form signs and dates the form.

Pages 310 through 312 are reserved for future use.

Reporting Food Assistance Changes, Form 470-2960 and 470-2960(S)

Purpose	Form 470-2960 and its Spanish translation, form 470-2960(S), are used to inform Food Assistance households how to report changes. The form shows the maximum gross monthly income for the household's size and explains ABAWD reporting requirements.
Source	Complete the English or Spanish version of form 470-2960 on line using the templates on the DHS Intranet eForms web page.
Completion	Issue this form: ♦ At application. ♦ At recertification.
Distribution	Send or give the original form to the household and keep a copy of the form in the case file.
Data	Complete the client name, date, and address on the form. Fill in the gross monthly income applicable for household size. Check the box and fill in the name of any able-bodied adults without dependents who work 80 or more hours per month.

Iowa Department of Human Services

Reporting Food Assistance Changes

Client name and address:

Date:

Case #:

Important information:

This form is for the Food Assistance Program only. If you receive Medical or FIP, you need to report changes for those programs within 10 days.

What do I have to report?

☒ You must tell us if your household's total monthly gross income goes over **$** _____ .

Step 1. **Gross income** is the amount of income before taxes and other deductions. At the end of each month, add up all gross income that everyone in your household got that month.

Step 2. If the total is more than **$** _____ you must tell us by the 10th of the next month.

☐ You must tell us if _____ stops working 80 or more hours in a month.

Step 1. At the end of each month add up the number of hours worked in that month.

Step 2. If the total number of hours is less than 80, you must tell us by the 10th of the next month.

You may report other kinds of things if you want to.

What if I don't report?

If you don't report when you should, you might have to pay us back for benefits you get. If you don't report on purpose, you risk being cut off of Food Assistance for a year or more.

How do I report?

Report changes to **1-877-DHS-5678** or **1-877-347-5678**. Changes may also be faxed to **1-877-238-0015** or e-mailed to **IMCustomerSC@dhs.state.ia.us.**

Iowa Department of Human Services

Reporting Food Assistance Changes
(Cómo informar sobre los cambios en la Asistencia Alimentaria)

Nombre y dirección del cliente:

Fecha:

Nº de Caso:

Información importante:

Este formulario es válido sólo para el Programa de Asistencia Alimentaria. Si usted recibe asistencia médica o FIP, necesita informar sobre los cambios para esos programas dentro de los 10 días.

¿Qué tengo que informar?

☒ Debe informarnos si el ingreso bruto total de su hogar supera los **$**_____ mensuales.

Paso 1. **El Ingreso Bruto** es el monto del ingreso antes de los impuestos y otras deducciones. Al finalizar cada mes, sume todos los ingresos brutos que cada persona de su hogar obtuvo ese mes.

Paso 2. Si el total suma más de **$**_____, usted debe informárnoslo antes del día 10 del mes siguiente.

☐ Debe informarnos si deja de trabajar 80 horas o más en un mes.

Paso 1. Al finalizar cada mes, sume el total de horas de trabajo de ese mes.

Paso 2. Si el número total de horas es menor a 80, usted debe informárnoslo antes del día 10 del mes siguiente.

Usted también puede informar acerca de otras cuestiones si así lo desea.

¿Qué sucede si no cumplo en informar?

Si usted no informa sobre estas cuestiones relevantes en su debido momento, es probable que tenga que pagarnos por los beneficios que recibe. Si no cumple en informar intencionalmente, corre el riesgo de no recibir Asistencia Alimentaria durante un año o más.

¿Cómo hago para informar?

Usted puede Informar sobre los cambios al **1-877-DHS-5678** o al **1-877-347-5678**. También puede hacerlo por fax al **1-877-238-0015** o por correo electrónico a **IMCustomerSC@dhs.state.ia.us.**

Review/Recertification Eligibility Document, Forms 470-2881, 470-2881(S), 470-2881(M), and 470-4083(MS)

Purpose

The *Review/Recertification Eligibility Document,* forms 470-2881, 470-2881(S), 470-2881(M), and 470-4083(MS), is designed for use as:

- An application for subsequent certification for the Food Assistance program.
- The annual or semiannual review document for FIP, Refugee Cash Assistance, and FMAP-related Medicaid.

This form contains instructions for completion and informs clients of their rights and responsibilities.

Source

Usually, the ABC system automatically generates form 470-2881. Form 470-2881(S) is generated when there is an "S" in the language indicator field on the ABC TD01 screen.

The manually issued English version, form 470-2881(M) is printed with 17 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa. It may also be completed on line using the template available on the DHS Intranet eForms web page.

The manually issued Spanish version, form 470-4083(MS) can be printed or photocopied from the sample in the manual.

Completion

The ABC system produces form 470-2881 after the data processing cutoff for:

- Food Assistance when a case is due for recertification.
- FIP, Refugee Cash Assistance, and FMAP-related Medicaid when a case is active, suspended, or pending and the case coding indicates that the form should be sent.

The local office gives or issues form 470-2881(M) or 470-4083(MS) to the participant upon request.

The worker or the ABC system completes the top portion of page 1 before the form is sent or issued to the participant.

The participant must complete the answers to all applicable questions. The participant may obtain help in completing the report from friends, relatives, advocate groups, or local office staff, if needed.

For FIP, Refugee Cash Assistance, and FMAP-related Medicaid, when both parents or a parent and a stepparent are in the home, either may sign the form. When a participant has a guardian or conservator, that person shall participate in completing the form. This person may sign for the client when necessary.

For Food Assistance, only one signature is required to process this form as an application for recertification.

Distribution

Give or mail one copy of the report to the client for completion.

File the completed original in the case record. Provide a copy of the completed form to the client upon request.

Data

Whenever the form is issued manually, provide a postage-paid envelope. Prepare the form as follows:

- Enter the county number.
- Enter the nine-digit case number and check digit.
- Enter the case name and current mailing address.
- Enter the local office name and mailing address.
- Enter the date the report is due in the local office at the top right hand corner and in "Read Carefully."
- Enter the worker's telephone number in the "What if I have questions?" section.
- For FIP, Refugee Cash Assistance, and FMAP-related Medicaid, leave the message section blank.

If an interview is needed for Food Assistance, enter:

"Your Food Assistance will end (last date of certification period). Return this signed form by (last month of certification period) 15th to get Food Assistance at the regular time next month, if you are eligible. You must have an interview. If you miss your interview, you must ask the local office to reschedule."

If an interview is not needed for Food Assistance, enter:

"Your Food Assistance will end (last date of certification period). Return this signed form by (last month of certification period) 15th to get Food Assistance at the regular time next month, if you are eligible."

- Enter all data in the "Household Members" section (except **do not** enter the last grade completed and the "yes" or "no" responses).

Screening: Screen the form upon its receipt. All questions (for related programs) that have "yes or no" responses must have either "yes" or "no" marked.

For FIP, Refugee Cash Assistance, and FMAP-related Medicaid if the answer is "yes," all requested information must be completed and necessary verification provided for the form to be considered complete.

If the participant fails to enter required information on the RRED but sends verification of that information with the RRED, the form is still considered complete.

Note: When the nonparental relative does not receive assistance for the relative's own needs, the information shall reflect the circumstances of each child.

To be complete, the form must be signed and dated by the necessary persons.

Iowa Department of Human Services

Statement of Citizenship Status

List each new person for whom you want benefits in the spaces below. (Use an additional form if necessary.) For each person, write down whether that person is a United States citizen, national, or alien. If the person is an alien, list the person's alien status and provide proof. (For Medicaid, proof will also be required if you are a citizen or national.) The signature of the head of household or applicant attests to the status of all household members.

Name	
This person is a ☐ Citizen ☐ National ☐ Alien	If an alien, what is person's status?

Name	
This person is a ☐ Citizen ☐ National ☐ Alien	If an alien, what is person's status?

Name	
This person is a ☐ Citizen ☐ National ☐ Alien	If an alien, what is person's status?

I CERTIFY, under penalty of perjury, by signing my name below, that I and the household members listed above are United States citizens or nationals or that the information I have given about household members' immigration status is correct.

I understand that I will need to provide the Department with proof of the immigration status of each person in my household who is not a United States citizen or national. (For Medicaid, proof will also be required if you are a citizen or national.) The proof can be either documentation from the U.S. Citizenship and Immigration Services (USCIS) or other documents the Department considers to be proof.

I understand that alien status may be subject to verification with USCIS. This requires submission of certain information from my case record to USCIS. I further understand that information received from USCIS may affect my household's eligibility and level of benefits.

Signatures

Your Signature	Date
Witness (if you signed with an X)	

Transitional Medicaid Notice of Decision/Quarterly Income Report, Forms 470-2663, 470-2663(S), 470-2663(M), and 470-2663(MS)

Purpose	The *Transitional Medicaid Notice of Decision/Quarterly Income Report*: ♦ Is used by clients to report the eligibility factors required to be reviewed for transitional Medicaid; and ♦ Transmits to the client the appropriate message regarding the client's continued eligibility under this coverage group.
Source	The ABC system automatically generates form 470-2663. Form 470-2663(S) is generated when there is an "S" in the language indicator field on the ABC TD01 screen. The manually issued English version, form 470-2663(M), may be initiated on line using the template available on the DHS Intranet eForms web page. Supplies of the manually issued Spanish version, form 470-2663(MS), may be printed or photocopied from the sample in the manual.
Completion	The ABC system generates form 470-2663 or 470-2663(S) for all active cases in the transitional Medicaid coverage group after the data processing system cutoff in the third, sixth, and ninth months of transitional Medicaid benefits. The form is mailed at the same time as the *Review/Recertification Eligibility Documents*. The system may also issue this form at other times in the month when the worker makes entries to request an out-of-cycle issuance. This may be done only in the fourth, seventh and tenth months of transitional Medicaid benefits and only for the current reporting period.

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

Account/Case Number

Social Security Number

RE: Amount of past due debt owed to Agency: $

Dear:

You have not paid the amount you owe to the Department of Human Services (DHS). You owe this debt because

If you do not pay your debt or take other action described below before 60 days from the date of this letter, DHS will submit your debt to the U.S. Department of the Treasury (Treasury) for collection. Pursuant to the Debt Collection Act of 1982 (DCA), as amended by the Debt Collection Improvement Act 1996 (DCIA), and appropriate Food Stamp Program regulations, we are authorized to add penalties, fees and other costs to your unpaid debt. Please note that the amount stated above is in addition to any other amount that may have been previously submitted by us to Treasury. DHS previously mailed or otherwise delivered demand letters notifying you about the claim, including the right to a hearing on the claim, and has made any other required collection efforts. In addition to you having had an opportunity to request a hearing on the claim, the claim is:

- Under 10 years old (unless it is covered by a court judgment);
- Equal to or exceeds the minimum amount established by Treasury;
- Not included under an automatic stay due to bankruptcy;
- Not currently under litigation; and
- Not currently being collected through allotment reduction or under a repayment plan that is currently approved by us.

Treasury collection: Once your debt is submitted, Treasury will reduce or withhold any of your eligible federal payments by the amount of your debt and may refer your debt to private collection contractors, the Department of Justice, or seek voluntary repayment. Collection of debts by Treasury is authorized by the DCA and DCIA. You may not receive another notice before your payment is offset. Federal payments eligible for offset include:

- Your income tax refunds, including any earned income tax credit payment you may be due (see attachment A for additional information);
- Up to 15% of federal salary pay, including military pay (See attachment A for additional information including how to request a waiver of this type of offset);
- Up to 25% of your federal retirement;
- Your military retirement pay;
- Your contractor/vendor payments;
- Other federal payments, including certain loans to you, that are not exempt from offset.

If you receive monthly federal payments, you should also know that the new law allows Treasury to withhold a limited amount of certain monthly federal benefits, such as Social Security Retirement, Survivors and Disability benefits, Railroad Retirement (other than tier 2) benefits, and Black Lung Part B benefits, to pay back your debt. You would be entitled to keep at least $750 per month or $9,000 per year of your federal payments. Treasury policies finalized September 1998 limit withholding to an amount that is up to 15% of your benefit payment. If you receive Supplemental Security income disability benefits (SSI) from the Social Security Administration, those benefits will not be withheld to pay back your debt.

Before we submit your debt to Treasury, we are required to tell you that you may

In addition, the attachment to this letter provides important information if you and your spouse file a joint income tax return

To avoid having your debt referred to Treasury you must do one of the following before 60 days from the date your notice has expired:

- **Repay your debt**: To repay your debt, send a check or money order, payable to: Department of Human Services, for the full amount that you owe to: Iowa Department of Human Services, Cashiers Office, Rm 14, 1305 E Walnut Street, Des Moines, IA 50319-0114. Please include a statement with your payment that the payment is being made to avoid having your payment referred to the Department of Treasury for food stamp offset.
- **Agree to a repayment plan**: If you are unable to pay your debt in full, you must contact Overpayment Recovery, 1-888-462-2152, agree to a repayment plan acceptable to us, and make payments in the repayment plan.
- **Bankruptcy**: If you filed for bankruptcy and the automatic stay is in effect, you are not subject to offset or other collection actions while the stay is in effect. Please notify us of the stay by sending evidence concerning the bankruptcy, to: Iowa Department of Inspections and Appeals, Division of Investigations, Lucas State Office Building, 321 E 12th Street, Des Moines, IA 50319-0083.

If you make or provide any knowingly false or frivolous statements, representations or evidence, you may be liable for penalties under the False Claims Act (31 U.S.C 3729-3731), or other applicable statutes, and or criminal penalties under 18 U.S.C 286,287,1001, and 1002, or other applicable statutes.

Unless prohibited by law or contract, we will promptly refund to you any amounts paid by you or deducted from your payment for your debt which are later waived or found not owed to the United States.

If you have any questions about this letter or your rights you should contact Overpayment Recovery, 1-888-462-2152 immediately.

ATTACHMENT A

If you file a joint income tax return:
If you file a joint income tax return and your spouse was not a member of the food stamp household at the time the overpayment occurred, you should contact the Internal Revenue Service before filing your return regarding the steps to take to protect the share of the income tax refund which may be payable to your spouse, who is not the delinquent debtor to the U.S. Government.

If you are a federal employee:
Your current net disposable pay is subject to offset if you do not pay your debt or take other action described above. Under the Treasury Offset Program (TOP), Treasury will deduct up to 15% of your disposable net pay beginning in the pay period that your debt is submitted for federal salary and wage offset and continuing every pay period until your debt plus fees, penalties, or other charges is paid in full.

When you are identified through TOP as receiving a federal salary or wage, you will be entitled to a hearing to dispute the existence or amount of the debt, or the amount of the payroll deduction. You will be provided information on where to file a written request for a hearing when you have been identified through TOP as receiving a federal salary or wage.

The timely filing of a petition for hearing will stay the commencement of offset proceedings for federal salary and wage offset; however, it will not stop offset of other types of federal payments. A final decision on the hearing (if one is requested) will be issued no later than 60 days after the filing of a petition requesting the hearing (unless extended by the hearing official).

As a federal employee, if you make or provide any knowingly false or frivolous statements, representations, or evidence, in addition to other penalties, you may be subject to disciplinary action.